STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Health Care, LLC	714 Southbend Avenue Mankato, MN 56001

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure body pillows used as positioning devices were not implemented as physical restraints for 3 of 3 residents (R5, R10 and R11) reviewed for restraints. Findings include: R5's face sheet dated 6/30/26, identified diagnoses of fracture of the right femur, osteoarthritis, dementia, osteoporosis, and history of falling.ˆ R5's admission Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment, had no behaviors, no rejection of care, had impairment on one side of lower extremity, used a walker, used a wheelchair, needed supervision/touching assistance for bed mobility, substantial/maximum assistance for transfers, had a fall in the last month prior to admission, had a fracture related to fall; in the 6 months prior to admission. Had no falls since admission.ˆ Had surgical repair of fracture of pelvis, hip, leg, knee, or ankle.ˆ R5's Fall incident report dated 5/5/26 at 9:20 a.m., identified R5 has a witnessed fall.ˆ Nursing assistant (NA) was in room and as she turned to get R5's shoes, R5 stood up and the NA was unable to catch her in time.ˆˆImmediate action taken was to place a body pillow under her sheets to alleviate any further falls from self-ambulation.ˆ Predisposing physiological factors of agitation, forgetful, unsteady gait, confusion, history of falls, not able to realize limitations, and gait imbalance.ˆ R5's fall focus care plan was revised on 5/6/26 to add intervention of body pillow placed under sheets to alleviate any further falls from self-ambulation. R5's Incident Review and Analysis formˆdated 5/6/26, identified R5's 5/5/26 fall while ambulating was reviewed. Causal factors of fall were identified as being confused and unable to tell what she was attempting to do.ˆ Current interventions in place at the time of the fall were 15-minute checks; anti-roll backs on wheelchair; bilateral grab bars on bed. ˆInterdisciplinary team (IDT) review added interventions toˆdiscontinue body pillow and have wheelchair locked at bedside.ˆ R5's care plan was revised on 5/8/26 to discontinue body pillow placed under the sheets and have R5's wheelchair locked at bedside. ˆR5's incident report dated 5/23/26 at 1:45 p.m., identified R5 was found on the floor at the foot of the bed lying on her left side.ˆ R5's family had placed R5 in bed without staff assistance.ˆStaff reported they had last checked on and toileted R5 at 1:15 p.m., where R5 was lying in bed.ˆˆ Immediate action taken was to send R5 to the emergency department for evaluation.ˆˆ R11's face sheet dated 6/29/26, identified diagnoses of hemiplegia and hemiparesis affecting left side and dementia. R11's Fall Review Evaluation dated 6/10/26, identified R11 was at risk for falls due to receiving scheduled narcotics, psychotropics, is incontinent of bowel and bladder, is alert and unaware of mobility limitations.ˆˆ R11's significant Change MDS dated [DATE], identified R11 had severe cognitive impairment, had no behaviors, no rejection of care, had lower extremity functional limitation, used a wheelchair, dependent with bed mobility, dependent for transfers, had no falls since admission/or retry or prior assessment. R11's fall focus care plan dated 9/6/23, identified R11 was at risk for falls related to human immunodeficiency virus, unspecified symptoms and signs involving cognitive functions and awareness, chronic pain syndrome.ˆ Goal to be safe and free from falls.ˆ Interventions included but were not limited to: -Body pillow for repositioning purposed when in bed. (dated 7/21/25)ˆ During an observation and interview on 6/26/26 at 1:10 p.m., R11 was observed (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lying in bed without a body pillow in place. NA-A retrieved a body pillow from a nearby chair, lifted the left side of the bed sheet, positioned the body pillow between R11 and the side of the bed underneath the sheet, and tucked the pillow securely into place. NA-A stated the body pillow was used to keep R11 in bed. R10's face sheet dated 6/30/26, identified diagnoses of hemiplegia (paralysis on one side of the body) and hemiparesis (partial weakness or loss of movement on one side of the body) following cerebral infarction (stroke).ˆ R10's quarterly Minimum Data Set (MDS) dated [DATE], identified R10 had moderate cognitive impairment, had physical behaviors directed towards other (such as hitting, kicking, pushing, scratching, or grabbing) that occurred daily, had verbal behaviors directed towards other (such as threating others, screaming at others, cursing at others) that occurred 4-6 day bud less than daily, rejection of care daily, needed substantial/maximum assistance for bed mobility and transfers, does not walk, no falls since admission/reentry/prior assessment, and no use of restraints. R10's mobility focus care plan dated 12/29/15, identified R10 had an alteration in mobility, at risk for falls and skin breakdown related to late effects of cerebral vascular accident (stroke) and hemiplegia.ˆ Goal to remain safe within the facility with no major injury. Interventions included but was not limited to -Pressure redistribution mattress to bed to prevent skin breakdown with body pillows to outline parameter of mattress (dated 12/30/15). ˆDuring an observation and interview on 6/26/26 at 1:08 p.m., R10 was lying in bed and on his left side where a body pillow had been tucked under the mattress sheet on the right side of the bed.ˆ NA-C stated that R10's body pillow was placed under the sheets tight so he did not remove the pillow, and the pillow also makes sure he did not attempt to try to get out or roll out of bed.ˆ NA-C stated, that is the way we have been placing body pillows for a long time, and we put them that way, so he does not remove it.ˆ During an interview on 6/26/26 at 1:18 p.m., nurse manager licensed practical nurse (LPN)-A stated body pillows should never be placed under the sheets to try and keep residents from getting out of bed, if they are used in this way, they become a restraint. LPN-A was not aware that staff had been placing body pillows in the manner they were and would need toˆdo some immediate education with the staff.ˆ During an interview on 6/26/26 at 3:59 p.m., director of nursing (DON) stated body pillows should never be placed under the sheets, so a resident was not able to remove them and by doing so, made the body pillow like a restraint.ˆ DON explained the facility had not completed a restraint assessment because they did not use restraints in the facility.ˆ ˆ Requested policy on restraints, but facility did not currently have a policy.ˆˆ

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to timely report a fall with major injury to the state agency (SA) within the required timeframe for 1 of 1 resident (R5) reviewed for falls. Findings include:R5's face sheet dated 6/30/26, identified diagnoses of fracture of the right femur (thigh bone), osteoarthritis (disorder where the protective cartilage that cushions the bones wears down), dementia, osteoporosis (a bone disease characterized by weak, brittle bones), and history of falling. R5's admission Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment, no behaviors, no rejection of care, had impairment on one side of lower extremity, used a walker/wheelchair, needed supervision/touching assistance for bed mobility, substantial/maximum assistance for transfers, had a fall in the last month prior to admission, had a fracture related to fall; in the 6 months prior to admission. Had no falls since admission. Had surgical repair of fracture of pelvis, hip, leg, knee, or ankle. R5's Vulnerable Adult Care Plan dated 4/25/26, identified R5 was categorically a vulnerable adult while resides in a skilled nursing facility. Resident was at risk due to decreased cognitive and physical abilities related to diagnosis of Lewy body dementia (a progressive brain disorder caused by abnormal protein) , disorientation, anxiety and visual hallucinations. Goal to remain free from abuse and/or neglect. Interventions as follows:-Staff will follow the facility vulnerable adult and abuse reporting policy. (dated 4/25/26)-The local ombudsman, adult protection, police, and state/financial agencies will be notified of any suspected abuse or financial exploitation as needed. (dated 4/25/25) R5's fall focus care plan dated 4/25/26, identified R5 was a fall risk related to impaired cognition, poor safety awareness, and impulsiveness as evidenced by fall history. Goal to be safe and free from injury. Interventions as follows:-15-minute checks (dated 4/29/26) R5's progress note dated 5/23/26 at 4:28 p.m., identified R5 was found at the foot of the bed lying on her left side at 1:45 p.m. R5's daughter had placed R5 in bed without assistance. Staff reported R5 was last checked on and toileted at 1:15 p.m. R5 was lying in bed when last seen. Range of motion was limited on left upper extremity. R5 unable to verbalize pain, so the FLACC Scale (an observational tool used for non-verbal or cognitively impaired individuals) and pain was 8/10 on pain scale. R5 was visibly yelling Help me. Provider called and gave order to send to the emergency department (ED). R5 was sent to the ED at 2:30 p.m. Review of R5's May 2026 Treatment Administration Record (TAR) identified a physician order for 15-minute behavioral checks every shift (dated 4/25/26 through 5/28/26). Although the TAR required staff to document only one entry per shift, it did not include documentation of the individual 15-minute checks performed throughout the shift.During an interview on 6/26/26 at 3:59 p.m., director of nursing (DON) stated during the facility investigation of R5's fall on 5/23/26 she had performed staff interviews and confirmed R5 had not been checked every 15 minutes as per her care plan fall prevention interventions nor did the facility have documentation showing that every 15 minutes someone put eyes on R5. DON explained family had been present prior to the fall and placed R5 in bed, however, staff should have checked on her every 15 minutes and according to the incident report it had been 30 minutes since R5 had been checked.^ DON explained R5 being impulsive and needing to be on 15-minute checks, staff should have continued to check on R5 every 15 minutes even if family was present to decrease the risk of her falling. DON further explained R5's fall on 5/23/26 did not get reported to the SA because she had been instructed by the corporate nurses that it did not need to be reported. DON could not articulate the rationale for not reporting this to the SA, however, she explained she was aware R5's care plan had not been followed at the time of the fall and per the incident report it had been 30 minutes since she had been checked on when her care plan indicated she was on 15 minute check. DON further explained this fall with serious injury should have been reported to the SA. Review of the facility's Abuse Prohibition/Vulnerable Adult Policy dated 11/25, identified the purpose to protect residents against (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals. Incidents that must be reported to the state agency were as follows: -Mistreatment-inappropriate treatment or exploitation of a resident. -Neglect - Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident. -Injuries of unknown source - an injury should be classified as an injury of unknown source. When both of the following conditions are met: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is in an area not generally vulnerable to trauma), or the number of injuries observed at one point in time or the incidence of injuries overtime.-All serious injuries that are determined to be a result of abuse, neglect, exploitation or misappropriation, even those considered accidental.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to complete a comprehensive fall analysis, evaluate and revise the care plan, and failed to implement fall interventions for 2 of 3 residents (R5, R11) who had severe cognitive impairment, impulsivity, and at high risk for falls. Findings include:Findings include: R5's face sheet dated 6/30/26, identified diagnoses of fracture of the right femur (thigh bone), osteoarthritis (disorder where the protective cartilage that cushions the bones wears down), dementia, osteoporosis (a bone disease characterized by weak, brittle bones), and history of falling.ˆ R5's admission Minimum Data Set (MDS) dated [DATE], identified R5 had severe cognitive impairment, no behaviors, no rejection of care, had impairment on one lower extremity, used a walker/wheelchair, needed supervision/touching assistance for bed mobility, substantial/maximum assistance for transfers, had a fall in the last month prior to admission, and had a fracture related to fall 6 months prior to admission. R5 had no falls since admission and had surgical repair of fracture of pelvis, hip, leg, knee, or ankle.ˆ R5's Fall Review Evaluation dated 4/24/26 at 12:47 p.m., identified R5 had multiple falls within the last 6 months, was taking three medications that may contribute to falls, was incontinent of urine and unable to independently come to a standing position. Summary/Interventions: Resident admitted to facility into secure memory care unit. Past medical history of falls. Recent fall with right lower extremity fracture and repair.ˆ Currently on hourly checks (However, review of R5's record did not include a comprehensive assessment linking R5's identified fall risk factors to the implementation of hourly checks as an intervention.) Will continue to evaluate quarterly, with change of condition and as needed.ˆ R5's progress note dated 4/24/26 at 10:48 p.m., identified R1 was admitted to the facility following a fall at home on 4/21/26 that resulted in a right femur fracture with surgical repair.ˆ R5's family wanted R5 to be on 15-minute checks until R5 gets used to facility.ˆ R5's family requested fall mat on floor. to prevent R5 from falling on the floor.ˆ Oncoming shift notified.ˆ Review of R5's record revealed that, although R5's family requested 15-minute safety checks, there was no documented assessment or re-evaluation to determine whether the existing hourly safety checks remained appropriate. Additionally, there was no evidence the care plan was revised to implement 15-minute safety checks and the fall matt on the floor. R5's fall focus care plan dated 4/25/26, identified R5 was a fall risk related to impaired cognition, poor safety awareness and impulsiveness as evidenced by fall history.ˆ Goal to be safe and free from falls.ˆ Care plan interventions as follows: -Follow resident specific fall prevention plan.ˆ Hourly checks. (dated 4/25/26 through 5/6/26) -Monitor and document on safety. Review information on past falls and attempt to determine root cause of falls.ˆ Record possible root causes. Alter/remove any potential causes if possible. Educated resident/family/caregivers as to causes. (dated 4/25/26) -Follow physical therapy and occupational therapy instructions for mobility function. (dated 4/25/2/26) ˆR5's progress note dated 4/25/26, identified R5 showed signs of agitation at 1p.m. and was attempting to stand up from her wheelchair.ˆ R5's progress note dated 4/27/26, identified R5 does try to get out of bed and staff assist her to reposition or get up depending on wishes.ˆ R5's progress note dated 4/28/26, identified R5 had been upgraded to assist of two for pivot transfers using a gait belt.ˆ R5 resting in bed, bed lowered and on 15-minute checks.ˆ Review of R5's care plan on 4/28/26 did not include bed height intervention nor identify revision to include an intervention for bed height. R5's fall focus care plan was revised on 4/29/26 to include the following interventions: -Anti-roll backs applied to wheelchair. -Bilateral grab bars applied to bed. -15-minute checks per family request. R5's Fall incident report dated 5/5/26 at 9:20 a.m., identified R5 has a witnessed fall.ˆ Nursing assistant (NA) was in room and as she turned to get R5's shoes, R5 stood up and the NA was unable to catch her in time.ˆ Predisposing physiological factors of agitation, forgetful, unsteady gait, confusion, history of falls, not able to realize limitations, and gait imbalance. Immediate action taken (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was to place a body pillow under her sheets to alleviate any further falls from self-ambulation.ˆ R5's Incident Review and Analysis form dated 5/6/26, identified R5's 5/5/26 fall while ambulating was reviewed. Causal factors of fall were identified as being confused and unable to tell what she was attempting to do.ˆ Current interventions in place at the time of the fall were 15-minute checks; anti-roll backs on wheelchair; bilateral grab bars on bed. ˆInterdisciplinary team (IDT) review added interventions to discontinue body pillow and have wheelchair locked at bedside.ˆ R5's fall focus care plan was revised on 5/6/26 to include body pillow placed under sheets to alleviate any further falls from self-ambulation. Although The Incident Review and Analysis dated 5/6/26 identified discontinuing the body pillow and locking the wheelchair at the bedside; despite these recommendations, R5's care plan was revised to add the body pillow intervention and did not include locking the wheelchair at the bedside. ˆR5's Medication Administration Record (MAR) default progress note dated 5/7/26 at 1:32 p.m., included a response for monitoring effectiveness of fall interventions which indicated that R5 does need help, and supervision while up in wheelchair due to her trying to stand up to prevent falls.ˆ R5's progress note dated 5/7/26 at 1:36 p.m., R5 needs supervision due to trying to walk alone and staff assist her to sit down.ˆ R5's progress note dated 5/8/26 identified R5 had been placed in her bed in the lowest position.ˆ Aide went to help another resident and as passing R5's room, R5 was observed sitting on the floor.ˆ R5 unable to state how she fell, neurological exams started, skin tear noted on right arm.ˆ Body pillow placed under her sheets to help alleviate any further falls from self-ambulation.ˆ Call light within reach and bed in the lowest position and fall mattress on the side of the bed.ˆˆ R5's incident report dated 5/8/26 at 5:20 p.m., identified R5 was found on the floor. R5's bed was in the lowest position and R5 had been placed in bed prior and after nursing assistant helped another resident, R5 was found on the floor. R5 sustained a skin tear on her right arm.ˆ Immediate action was fall matt placed on side of bed.ˆ R5's Incident Review Analysis dated 5/8/26 however signed by IDT on 5/13/26 identified a causal factor of R5 assisted to lay in bed after dinner, bed was in lowest position and R5 has a small skin tear on her right arm.ˆ IDT review and determined bed to be at appropriate height with feet touching flat on the floor when sitting at the edge of the bedside. Continuing physical therapy to improve strength and mobility and walking program initiated to ambulate twice daily for staff assist.ˆ The fall record did not include a comprehensive fall analysis that would include but not limited to R5's last known well time, pain presence, or if toileting needs were met. R5's care plan was revised on 5/8/26 identified the body pillow intervention was discontinued which had been directed to be discontinued on 5/6/26 according to the Incident Review. A new intervention was added that directed staff to have R5's wheelchair locked at bedside. However, the care plan was not revised to include the floor matt as per the progress note on 4/24/26 and was not revised to address the bed height as per the analysis and the progress note on 4/28/26. R5's progress note dated 5/9/26 at 3:54 p.m., identified R5 attempting to stand from her wheelchair.ˆ As writer approached resident she dug her nails into writer's arm.ˆ The family called to come and sit with resident and resident calmed down.ˆˆ R5's progress note dated 5/10/26 at 10:15 p.m., identified R5 agitated at supper time and keeps standing up to her wheelchair.ˆ R5's care plan was revised on 5/11/26 to include the interventions: bed at appropriate height [height not specified], no fall mat, no low bed, and a soft-touch call light clipped to the side of the bed. Review of R5's record revealed no comprehensive assessment or evaluation supporting the discontinuation of the fall mat and low bed interventions. R5's progress note dated 5/12/26 at 6:18 p.m., identified R5 may sit for a while but then sits and stands up, required staff member to stay with her when she was doing this.ˆ Does get up and down in bed.ˆ Monitored for safety. Anti-tip legs put on wheelchair to prevent her wheelchair from tipping over.ˆ R5's progress note dated 5/15/26 at 4:20 p.m., identified R5 was self-transferring at 8:00 a.m. across from the dining room. R5 was immediately redirected to her wheelchair and attempted to stand up from her wheelchair multiple times.ˆ R5 toileted and laid down for a nap after breakfast.ˆ R5's progress note dated 5/16/26 at 7:50 p.m., identified R5 gets up and starts to stand and walk on own, staff assist as soon as seen.ˆˆ R5's (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress note dated 5/18/26 at 4:11 p.m., identified R5 will stand up from her wheelchair and staff assist.^^ R5 does not comprehend that she needs help for safety purposes.^ R5's progress note dated 5/20/26 at 11:14 a.m., identified R5 walked with nursing assistant today and was much steadier than last week. R5 needed observation as to prevent her from getting up alone. R5's progress note dated 5/20/26 at 12:48 p.m., identified R5 sitting longer in wheelchair before trying to get up alone.^ Staff needed to be there to monitor and visit with her as she would get up and stand.^^ R5's progress note dated 5/23/26 identified R5 was found at the foot of the bed lying on her left side at 1:45 p.m.^ R5's daughter had placed R5 in bed without assistance.^ Staff reported R5 was last checked on and toileted at 1:15 p.m. R5 was lying in bed when last seen.^ Range of motion was limited to left upper extremity.^ R5 unable to verbalize pain, so the FLACC Scale (an observational tool used for non-verbal or cognitively impaired individuals) was used and R5's pain was rated 8/10 on the pain scale. R5 was stating, Help me. Provider called and gave order to send to the emergency department (ED).^ R5 was sent to the ED at 2:30 p.m.^ R5's ED note dated 5/23/26, identified R5 was seen following a fall in the nursing home. R5 was having left arm and left leg pain.^ Imaging completed of left shoulder which revealed an acute transverse fracture (a type of complete bonce break where the line runs horizontally, perpendicular to the long axis of the bone, usually caused by high impact trauma like a fall, car accident, or direct blow.) of the left humeral head/neck junction.^ Family did not want any surgical interventions, so R5 was placed in a sling and will be discharged back to the nursing home.^ R5's incident report dated 5/23/26 at 1:45 p.m., identified R5 was found on the floor at the foot of the bed lying on her left side.^ R5's family had placed R5 in bed without staff assistance.^ Staff reported they had last checked on and toileted R5 at 1:15 p.m., where R5 was lying in bed.^^ Immediate action taken was to send R5 to the emergency department for evaluation.^ Although R5's care plan identified R5 required every15-minute checks, the incident report documented R5 had not been checked for 30 minutes prior to the fall on 5/23/26 at 1:45 p.m. R5's Incident Review and Analysis dated 5/23/26, identified R5's fall on 5/23/26 at 1:45 p.m. was reviewed.^ Causal factors for incident are that R5 was found on the foot of the bed lying on her left side at 1:45 p.m.^ Family assisted R5 to bed before that.^ R5 was last toileted at 1:15 p.m. ^^Other (new) inventions: bed in lowest position and body pillow for positioning and defining the edge of the bed.^ Although R5's care plan indicated 15-minute checks, the Incident Review and Analysis did not identify that the care plan was not followed. Review of R5's May 2026 Treatment Administration Record (TAR) identified a physician order for 15-minute behavioral checks every shift (dated 4/25/26 through 5/28/26). The TAR required staff to document only one entry per shift, it did not include documentation of the individual 15-minute checks performed throughout the shift. R5's progress note dated 9:59 p.m., identified at R5 arrived back at the facility at 6:24 p.m. and wearing a sling.^ Soft touch call light placed and attached to sheet.^ R5's care plan was revised on 5/24/26 to have bed in lowest position, body pillow for positioning and defining the edge of the bed. Do not tuck body pillow under bed sheets.^ During an interview on 6/26/26 at 1:18 p.m., licensed practical nurse care coordinator (LPN)-A stated after a resident has fallen, she would add the information of what events occurred during the time of the fall, however, she did not review if R5 had been checked on every 15-minutes per the care plan, had toileting needs met, and had not determined fall prevention interventions had been implemented at the time of the fall as part of root cause analysis. During an interview on 6/26/26 at 3:59 p.m., director of nursing (DON) stated during the facility investigation of R5's fall on 5/23/26 she had performed staff interviews and confirmed R5 had not been checked every 15 minutes as per her care plan nor did the facility have documentation showing that every 15 minutes check increments were completed by staff. DON explained family had been present prior to the fall and placed R5 in bed, however, staff should have checked on her every 15 minutes and according to the incident report it had been 30 minutes in between since R5 had been checked.^ DON explained R5 being impulsive and needing to be on 15-minute checks, staff should have continued to check on R5 every 15 minutes even if family was present to decrease the risk of her falling. During an interview on (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/26/26 at 4:07 p.m., administrator stated she had identified following R5's fall with fracture on 5/23/26 that the facility had only been documenting 15-minute checks once per shift instead of recording every 15-minute. Administrator explained on 5/23/26 the facility changed the process of documentation for staff to document every 15 minutes versus once per shift and this documentation would be on paper to ensure compliance. During an interview on 6/30/26 at 4:19 p.m., the medical director (MD) stated it was her expectation that staff ensure fall prevention interventions were implemented to mitigate the risk of falls with serious injury. The MD further stated that the facility's failure to implement those interventions for R5 resulted in a fall on 5/23/26 that caused a fracture. R11 R11's face sheet dated 6/29/26, identified diagnoses of hemiplegia and hemiparesis affecting left side and dementia. R11's Fall Review Evaluation dated 6/10/26, identified R11 was at risk for falls due to receiving scheduled narcotics, psychotropics, is incontinent of bowel and bladder, is alert and unaware of mobility limitations.^^ R11's Significant Change MDS dated [DATE], identified R11 had severe cognitive impairment, had no behaviors, no rejection of care, had lower extremity functional limitation, used a wheelchair, dependent with bed mobility/transfers, had no falls since admission/or retry or prior assessment. R11's fall focus care plan dated 9/6/23, identified R11 was at risk for falls related to human immunodeficiency virus, unspecified symptoms and signs involving cognitive functions and awareness, chronic pain syndrome.^ Goal to be safe and free from falls.^ Interventions as follows: -Monitor and document on safety. Review information on past falls and attempts to determine cause of falls.^ Record possible root causes.^ Alter/remove any potential causes if possible.^ Educate resident/family/caregivers/IDT as to causes (dated 9/23/23). -Follow physical therapy (PT) and occupational therapy (OT) instructions for mobility function (dated 9/6/23). -Call light within reach (dated 9/10/23). -Dycem (anti-slip mat) to top of cushion in Broda (a specialized positioning chair) wheelchair (dated 1/26/24).^ -Body pillow for repositioning purposed when in bed (dated 7/21/25). ^ -Fall mat beside bed (dated 12/15/25). R11's progress note dated 6/25/26 at 1:43 p.m., identified R11 was seated on the floor in the dining room.^ R11's back and head was resting against the seat and leg rest on the chair.^ R11's chair was in the upright position.^ Immediate intervention was to maintain the Broda chair in the tilted back position whenever the resident is not actively eating to promote positioning and reduce the risk of forward sliding.^^ R11's Incident Review and Analysis form dated 6/26/26, identified R11 was observed slip down out of Broda chair and sat on bottom on the floor.^ Intervention to reposition with total mechanical lift after meals to ensure resident has safe body alignment within chair and must lay down after 1 hour of being up in Broda chair.^^ R11's care plan was revised on 6/26/26 to reposition with total mechanical lift and two staff after meals to ensure resident has safe body alignment within chair. Must lay down after 1 hour of being up in the Broda chair.^^ During an observation and interview on 6/30/26 at 1:10 p.m., R11 was lying in bed without a fall mat on the floor nor a body pillow for positioning according to the care plan. Nursing assistant (NA)-A entered R11's room where R11 was lying in bed.^ NA-A stated R11's fall interventions were supposed to be a fall mat in place and a body pillow on the side of the bed next to him.^ NA-A had placed R11 in bed after lunch, however, had not placed the fall mat on the floor next to his bed nor put the body pillow in place.^ NA-A then took the body pillow and placed it on the left side of the bed tucked under the sheet of R11, however, NA-A did not put the fall matt next to R11's bed. As NA-A was leaving R11's room surveyor asked NA-A if the matt was supposed to be placed. NA-A then placed the fall mat on the floor next to R11's bed and explained R11 should have had this placed as soon as he was transferred into bed to prevent injury if he were to fall out of bed. During an interview on 6/26/26 at 1:18 p.m., nurse manager licensed practical nurse (LPN)-A stated it was her expectation for all staff to ensure that the fall prevention interventions are utilized for a resident at risk for fall to mitigate the risk of injury if they do fall. LPN-A explained R11's body pillow was not supposed to be tucked under the sheet when he was in bed and was just supposed to be laid on the top of the sheet for positioning to make help define the bed. R11's fall mat should have been placed on the floor as soon as R11 was placed in bed.^ ^ ^^ During an interview on 6/26/26 at 3:59 p.m., DON (continued on next page)

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	245507	A. Building B. Wing	06/30/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated it would be her expectation for staff to ensure all fall prevention interventions are utilized at all times to mitigate the risk of falling and to try and mitigate the risk of injury if the resident does fall.^^ Review of the facility's Fall Prevention and Management Policy dated 11/25, identified the following: Managing Falls and Fall Risk: -Facility staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. -If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on the nature of or type of fall, until falling is reduced or stopped or until the reason for the continuation of the falling is identified as unavoidable. -Staff may also identify and implement relevant interventions to try to minimize serious consequences of falling. -Staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to comprehensively assess and monitor fluid intake to ensure adequate hydration for 1 of 3 residents (R3) reviewed for dehydration. Findings include: R3's face sheet dated 6/26/26, identified diagnoses of malignant neoplasm of brain, type 2 diabetes, moderate protein-calorie malnutrition, and absence of right leg below knee. R3's significant change of status Minimum Data Set (MDS) dated [DATE], identified R3 had no memory issues. R3 had no vision or hearing impairments. R3 rejected cares 1-3 days per week, had impairment on both sides of upper and lower body, was independent with eating, moderate assistance with upper body dressing and dependent on lower body dressing. R3's nutritional care plan updated 5/23/26, identified a goal of maintain adequate hydration status. Interventions included to offer adequate fluids at and between meals beginning 11/28/25 and obtain/review labs per doctor orders. R3's Clinical Nutrition Evaluation V-5 dated 3/4/26, did not identify R3's fluid requirements however, indicated R3's daily fluid intake consumed was 1500-2000 cubic centimeters (cc) daily. The evaluation included the goal maintain adequate hydration status Consume 75% meals and supplements. R3's Fluid Intake record identified inconsistent documented individual fluid intakes consumed. However, there was no indication the 24-hour daily fluid intake was calculated and evaluated to determine whether R3 met hydrations needs even though multiple 24-hour daily consumptions documented did not exceed 1000 ml when calculated. 4/7/26: Fluid intake documented as 480 mL at 1:34 p.m., 480 mL at 1:35 p.m., and 600 mL at 7:01 p.m. The documented fluid intake entries totaled 1,560 mL. 4/8/26: Fluid intake documented as 480 mL at 10:00 a.m., 480 mL at 1:10 p.m., and 600 mL at 6:28 p.m. The documented fluid intake entries totaled 1,560 mL. 4/9/26: Fluid intake documented as 240 mL at 1:37 p.m., 240 mL at 1:37 p.m., and 600 mL at 6:24 p.m. The documented fluid intake entries totaled 1,080 mL. 4/10/26: Fluid intake documented as 240 mL at 1:11 p.m., 240 mL at 1:11 p.m., and 240 mL at 6:13 p.m. The documented fluid intake entries totaled 720 mL. 4/11/26: Fluid intake documented as Resident Refused at 6:47 p.m. 4/12/26: Fluid intake documented as Resident Refused at 6:10 p.m. R3's progress note dated 4/12/26 at 4:20 p.m., identified at 1:30 p.m., R3 had an unresponsive episode after transferring on the mechanical standing lift. R3 had complained of feeling dizzy while standing on the machine and when R3 sat down on the bed, went unresponsive. Nursing assistant (NA) reported R3 did not respond to shoulder shake or name being called. NA was unable to determine approximate length of time R3 was unresponsive and informed nurse after R3 came to. Assessed vital signs: temperature 98.2 (normal range 97.8-99.0), pulse 64 (normal range 60-100), respirations 16 (normal range 12-18), blood pressure 80/51 (normal range 90/60-120/80), oxygen 90% room air (normal range 95-100%). Physician contacted and advised sending to emergency department (ED) for evaluation. R3's Emergency Department (ED) After Visit Summary dated 4/12/26, identified R3 was seen at the ED for loss of consciousness. Testing showed signs of dehydration and R3 received intravenous fluids. R3 was to continue to increase water intake. R3's progress note dated 4/12/26 at 7:26 p.m., identified R3 returned from ED at 6:30 p.m. Diagnoses-syncope (fainting) and failure renal acute (acute kidney injury) and signs of dehydration. Continue to increase water intake. Drink less juice. Review of R3's record dated 4/12/26 identified R3's care plan was not revised to include management and/or prevention strategies for signs/symptoms of dehydration, acute renal failure, and syncope. In addition, the record did not identify re-assessment of R3's daily fluid needs and goals in conjunction with defined how much fluid staff were to encourage. R3's Treatment Administration Record (TAR) for 4/2026, identified a nursing order on 4/12/26, Per ED visit continue to increase water intake. Follow up with primary care provider in the next 1-2 weeks for re-evaluation and repeat kidney function testing. Return to ED if any new or worsening symptoms, chest pain, shortness of breath, repeat passing out or any other concerns every shift until 4/20/26. This order included a +/- and each shift marked, however, did not include a corresponding symbol key in order to ascertain (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meaning of documented +, -', or 0. The TAR identified on 4/12/26 night shift marked 0. On 4/13/26-4/20/26 each shift marked +. On 4/20/26, night shift marked - . Order was discontinued 4/21/26. R3's Extended Care Visit Note dated 4/13/26, identified R3 was seen for ED visit on 4/12/26, for syncope/dehydration, with a diagnosis of acute renal failure. ED had advised increased fluid intake and close follow-up with primary care provider for re-evaluation of renal function. Orders to obtain basic metabolic panel (BMP) in one week. R3's progress note dated 4/14/26 at 12:27 a.m., identified R3 came to dining area for supper. No dizziness noted. Has been drinking more water per doctor order. R3's record did not identify amounts. R3's Extended Care Visit Note dated 4/27/26, identified BMP was stable and reviewed on 4/21/26, continue current plan of care. R3's Fluid Intake record identified inconsistent documented individual fluid intakes consumed. However, there was no indication the 24-hour daily fluid intake was calculated and evaluated to determine whether R3 met hydrations needs even though multiple 24-hour daily consumptions did not exceed 1000 ml when calculated. 4/13/26: Fluid intake documented as 240 mL at 1:55 p.m., 240 mL at 1:55 p.m., and 240 mL at 6:55 p.m. The documented fluid intake entries totaled 720 mL. 4/14/26: Fluid intake documented as 240 mL at 1:26 p.m. and 240 mL at 1:26 p.m. The documented fluid intake entries totaled 480 mL. 4/15/26: Fluid intake documented as 480 mL at 1:14 p.m. and Resident Refused at 6:02 p.m. The documented fluid intake entries totaled 480 mL. 4/16/26: Fluid intake documented as 240 mL at 1:29 p.m., 240 mL at 1:29 p.m., and 0 mL at 6:38 p.m. The documented fluid intake entries totaled 480 mL. 4/17/26: Fluid intake documented as 240 mL at 1:28 p.m., 240 mL at 1:28 p.m., and 240 mL at 7:06 p.m. The documented fluid intake entries totaled 720 mL. 4/18/26: Fluid intake documented as 240 mL at 1:27 p.m., 240 mL at 1:42 p.m., and 600 mL at 7:20 p.m. The documented fluid intake entries totaled 1,080 mL. 4/19/26: Fluid intake documented as 240 mL at 1:24 p.m., 240 mL at 1:24 p.m., and 480 mL at 6:49 p.m. The documented fluid intake entries totaled 960 mL. 4/20/26: Fluid intake documented as 480 mL at 10:16 a.m., Resident Not Available at 1:00 p.m., and 600 mL at 6:38 p.m. The documented fluid intake entries totaled 1,080 mL. 4/21/26: Fluid intake documented as 240 mL at 1:40 p.m., Not Applicable at 1:41 p.m., and 240 mL at 6:18 p.m. The documented fluid intake entries totaled 480 mL. 4/22/26: Fluid intake documented as 600 mL at 6:08 p.m. The documented fluid intake entry totaled 600 mL. 4/23/26: Fluid intake documented as 240 mL at 2:03 p.m., 240 mL at 2:03 p.m., and 600 mL at 7:01 p.m. The documented fluid intake entries totaled 1,080 mL. 4/24/26: Fluid intake documented as 240 mL at 6:52 p.m. The documented fluid intake entry totaled 240 mL. 4/25/26: Fluid intake documented as 240 mL at 1:46 p.m. and 240 mL at 1:46 p.m. The documented fluid intake entries totaled 480 mL. 4/26/26: Fluid intake documented as Resident Refused at 1:17 p.m. and 440 mL at 1:17 p.m. The documented fluid intake entries totaled 440 mL. 4/27/26: Fluid intake documented as Resident Refused at 10:16 a.m., 240 mL at 1:24 p.m., and 240 mL at 5:37 p.m. The documented fluid intake entries totaled 480 mL. 4/28/26: Fluid intake documented as 0 mL at 1:24 p.m., Resident Refused at 1:24 p.m., and 240 mL at 6:38 p.m. The documented fluid intake entries totaled 240 mL. 4/29/26: Fluid intake documented as 240 mL at 1:10 p.m., 240 mL at 1:10 p.m., and 240 mL at 6:43 p.m. The documented fluid intake entries totaled 720 mL. 4/30/26: Fluid intake documented as Not Applicable at 11:59 a.m., Not Applicable at 11:59 a.m., and 240 mL at 6:56 p.m. The documented fluid intake entries totaled 240 mL. 5/1/26: Fluid intake documented as 240 mL at 1:38 p.m. and 240 mL at 1:38 p.m. The documented fluid intake entries totaled 480 mL. 5/2/26: Fluid intake documented as 480 mL at 11:20 a.m., 480 mL at 2:06 p.m., and 600 mL at 7:23 p.m. The documented fluid intake entries totaled 1,560 mL. 5/3/26: Fluid intake documented as 480 mL at 1:30 p.m. and 480 mL at 1:35 p.m. The documented fluid intake entries totaled 960 mL. 5/4/26: Fluid intake documented as 240 mL at 12:59 p.m., 240 mL at 12:59 p.m., and 240 mL at 7:03 p.m. The documented fluid intake entries totaled 720 mL. 5/5/26: Fluid intake documented as 480 mL at 1:47 p.m., 480 mL at 1:48 p.m., and 240 mL at 6:36 p.m. The documented fluid intake entries totaled 1,200 mL. 5/6/26: Fluid intake documented as 240 mL at 9:49 a.m., 480 mL at 1:27 p.m., and 240 mL at 7:30 p.m. The documented fluid intake entries totaled 960 mL. 5/7/26: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fluid intake documented as 240 mL at 6:39 p.m. The documented fluid intake entry totaled 240 mL. R3's progress note dated 5/7/26 at 4:43 p.m., identified R3 had head pain at 1:00 p.m. BP taken at 83/38 and on opposite arm 94/46. R3 rated pain 10/10. Went to get VS after 15 minutes and R3 had shallow respirations, O2 was 86% on room air. BP 91/48. R3 did not respond to questions on pain and sternal rub performed. R3 stated pain was high. R3 stated it was March and Saturday. R3 was sent to ED for evaluation. R3's ED Discharge summary dated [DATE], identified R3 went to ED for a headache. R3 had low blood pressure for emergency medical crew, fluids given and dehydration favored per medical doctor (MD). Critical care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: dehydration. R3's blood, urea, nitrogen (BUN) was 25 (normal range 8-24) and blood pressure prior to intravenous fluids was 88/56. R3 was provided with 1,000 mL of NaCl (normal saline) and discharge blood pressure was 133/86. Headache resolved with fluids and Tylenol and no orders were provided by ED. R3's Extended Care Visit Note dated 5/11/26, identified R3 was seen for a follow-up ED visit from 5/7/26, with a diagnosis of headache. No new orders, continue current plan of care. R3's progress note dated 5/13/26 at 3:15 p.m., identified water pass done in morning per usual. Removed three 550 mL mugs (two had juice, one had water) from R3's room. replaced with one 550 mL of ice water and one 550 mL of cranberry juice with ice. At 3:17 p.m., progress note identified R3 also orders a 550 mL mug of cranberry, apple, or lemonade at each meal and carries it with him if not done at meals. Often sits by north door with a mug of juice and ice multiple times daily. At 3:21 p.m., progress note identified R3 ordered a 550 mL mug of cranberry juice at lunch. R3 had consumed 400 mL of cranberry juice from 11:00 a.m. until 3:24 p.m. Water mug from morning water pass had 250 mL left in it. Will continue to encourage water intake. R3's progress note dated 5/23/26, indicated R3 was admitted to hospice. R3's Fluid Intake Record for between 5/13/26 through 5/31/26 identified inconsistent individual fluid intake entries with calculated or documentation a total daily fluid intake. Based on a calculation of the documented individual fluid intake entries, the resident's daily fluid intake ranged from 480 mL to 2,480 mL, with an average daily intake of approximately 1,121 mL after excluding the 18,000 mL entry documented on May 27. R3's Clinical Nutrition assessment dated [DATE], completed by registered dietician identified R3's fluid needs as 1850 cc's-2200 cc and R3 was meeting nutritional needs with a documented intervention as hospice cares. Resident to remain as nourished and hydrated as disease state allows. Goal is comfort. Food and fluids as desired and tolerated. During an interview on 6/30/26 at 8:16 a.m., nursing assistant (NA)-D stated as far as he was aware culinary services charted fluid intake for residents. NA-D could not recall ever recording fluid intake on fluids consumed outside of the meals. R3 seemed to be very thirsty, asking for water a lot. R3 had very dry skin and we had to lotion/moisturize it morning and night. During an interview on 6/30/26 at 9:00 a.m., NA-E stated she did not record fluid intake. R3 had very dry skin and did not drink a lot. Staff encouraged R3 to drink water or juice frequently. During an interview on 6/30/26 at 9:22 a.m., NA-F stated dietary staff monitor and record fluid records for residents, not NA's. NA-F thought nurses might record fluids that were not given in the dining room. During an interview on 6/30/26 at 8:30 a.m., cook (C)-A stated dietary did not record fluids consumed from the water mugs that were passed out in the morning and evening. C-A was unsure if any staff monitored a 24-hour fluid intake for residents to determine if they had enough fluids each day. During an interview on 6/30/26 at 11:47 a.m., registered nurse (RN)-A stated nurses keep track of fluid that they give for residents on fluid restriction. Nurse would record the amount in the treatment administration record (TAR). RN-A thought someone checked daily for 24-hour fluid intake but was unsure who and thought maybe it would be the nurse manager. During an interview on 6/30/26 at 1:46 p.m., RN-B stated fluid could be determined by checking daily weight. All residents require 1,000 milliliters (mL) per day. RN-B reviewed R3's fluid intakes from April-June and stated the + sign indicated that the resident received 1,000 mL that day. RN-B then stated the + meant to increase fluid but it did not specify exactly how much. RN-B stated NA's report to the nurse how much fluid the resident takes and would follow-up with kitchen and electronic record to (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determine fluid amount. R3 would be at risk for dehydration. RN-B stated nurses monitor what fluid is consumed during their shift but was unsure if anyone monitored total daily fluid intake. During an interview on 6/30/26 at 12:42 p.m., director of nursing (DON) stated typically dietary staff monitored fluid intakes but nursing would monitor in the TAR if needed. A checkmark or plus/minus sign would not give a good idea of fluid intake or give a specific amount of fluid consumed. DON questioned What does the + or minus mean without a corresponding progress note. DON would expect the documentation to include how many mL's were offered and how many were consumed. Sometimes, residents just needed to be encouraged to drink more fluids but occasionally the dietician or doctor would consult for goals of fluid intake. DON guessed that the interdisciplinary team (IDT) had determined that R3 had adequate fluid intake and did not need additional monitoring. However, DON was unable to find corresponding documentation that IDT had reviewed R3's fluid intake. The facility Hydration Program policy dated 6/2026, identified between meals, culinary services provides clean water pitchers or cups for between-meal hydration. The assigned department will pass water to all residents who are medically appropriate to receive it. Pitchers will be retrieved and sent to kitchen for cleaning and sanitizing at least daily. Thickened water will be passed as applicable. The facility Monitoring Food and Fluid Consumption revised 6/2026, identified all residents, including those who receive meal trays, will be monitored for dietary intake during each meal. Hospitality Services Director and Registered Dietician will review dietary intake. Recommendations will be made to improve nutritional status as necessary.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and document review the facility failed to safely store medications by allowing medications to be removed from their original labeled containers, permitting loose and unidentified medications to remain in medication carts, failing to properly label medications after opening, and failing to remove expired medications from active stock on 2 of 2 medication carts observed. Findings include During an observation and interview on 6/25/26 at 4:17 p.m., registered nurse (RN)-A opened the top drawer of the medication cart. Inside the cart there were three white souffle cups filled with medications. RN-A stated she currently had three residents' medications set-up in the top drawer. RN-A put the resident room numbers on the bottom of the souffle cups, so she knew whose medications they were. RN-A stated she always set medications up in the top drawer, so they were ready to distribute if I am really busy at least it is ready for them or me to give it to them. It saves a lot of time for me. During an observation and interview on 6/26/26 at 8:13 a.m., licensed practical nurse (LPN)-B opened the medication cart and removed Refresh Tears eye drops. LPN-B stated the Refresh Tears were house stock so did not need a resident identifier on them or an open date as they were individual filled Tears. Another Refresh Tears was labeled with a resident name, however, did not have a date when the bottle was opened. LPN-B stated eye drops were good for 30 days from the date they were opened. Without the open date, LPN-B would not be able to identify if the eye drops were expired or not it is pretty full though. A lidocaine patch was loose in the top drawer, and a white souffle cup with medications were also in the top drawer. I don't know whose meds are in the top drawer. They were here when I got here, assuming from the night shift. LPN-B verified there were four white pills in the medication cup. LPN-B stated she would not be able to know who the medications belonged to or what they were. it is not good practice to do that. LPN-B stated she was going to destroy the medications. During an observation and interview on 6/26/26 at 10:17 a.m., trained medication aide (TMA)-A opened the medication cart she was working on and found one bottle of Refresh eye drops with no date. TMA-A stated the eye drops should be labeled with an open date and the expiration date. TMA-A was going to remove the eye drops from the cart and destroy them. TMA-A noted inhalers were together in the cart. inhalers should be separated out and in their own box. A bottle of Latanoprost eye drops had an open date of 4/27/26 with an expiration date of 6/8/26. Latanoprost should not have been used after the expiration date. During an interview on 6/26/26 at 10:34 a.m., assistant director of nursing (ADON) stated eye drops should not be used beyond the expiration date. Inhalers should be kept separate and in their own individual bag with the resident name on it. The pharmacy does a monthly audit and provides feedback on the medication carts. During an observation on 6/26/26 at 10:40 a.m., ADON went to LPN-B's medication cart. LPN-B verified with ADON that there was a cup of four pills in the cart when she came on-shift that she did not know who they belonged to either. ADON instructed LPN-B to open the medication cart so she could complete an audit on medications. Once the cart was opened, ADON found two Loperamide 2 milligram (mg) tablets in individual packages; 18 tablets of Tylenol 325 mg in a medication cup; Two Rosuvastatin 5 mg tablets not in packaging in top drawer; one 14 mg Nicotine patch with an expiration date of 5/28/26; 10 Bisacodyl 5 mg tablets loose in top drawer; two random individually filled eye drops; One tablet Bupropion 100 mg; One tablet Carbidopa-Levodopa 25-100 mg; One tablet Cymbalta 60 mg; ADON stated this is not acceptable, I am sick. One tablet Gabapentin 100 mg; One tablet Carbidopa-Levodopa 50-100 mg; One half tablet Sertraline 50 mg; one tablet Seroquel 25 mg; and two tablets Haloperidol unknown strength. ADON stated this was not okay, it was not evidence based or best practice. ADON stated the facility would be having a big conversation about this. ADON was going to destroy the medications that were just found loose in the top drawer of the medication cart. The facility Medication Storage in the Facility policy dated 2/2026, identified the (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provider pharmacy dispenses medications in containers that meet regulatory requirements. Medications are kept in these containers. Nurses may not transfer medications from one container to another or return partially used medications to the original container. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating. The nurse will check the expiration date of each medication before administering it. No expired medication will be administered to a resident. All expired medications will be removed from the active supply and destroyed in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Health Care, LLC	714 Southbend Avenue Mankato, MN 56001

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure proper handwashing/hand hygiene was implemented for 1 of 3 residents (R13) observed during incontinence cares. In addition, the facility failed to ensure enhanced barrier precautions (EBP) were utilized during a transfer for 1 of 3 residents (R13).Findings include:R13's face sheet dated 6/30/26, identified diagnoses of diabetes, dementia, chronic kidney disease, and retention of urine.R13's significant Change Minimum Data Set (MDS) dated [DATE], identified R13 had moderate cognitive impairment, had no behaviors, had rejection of cares that occurred 1-3 days, had limitations in range of motion on lower extremity, used a wheelchair, was dependent for toileting hygiene, substantial/maximum assistance for bed mobility, dependent for transfers, and had an indwelling catheter.R13's care plan dated 6/11/26, identified R13 was currently on EBP related to catheter care and wound care. Goal of staff to follow EBP. Interventions added on 6/11/26as follows:-Use appropriate communication to follow EBP. Explain reason for use of enhanced barrier precautions (catheter, cares, and wound cares) (dated 6/11/26).-Staff to DON (apply)/DOFF (take off) personal protective equipment per EBP policy when providing high contact cares (catheter care and wound care) (dated 6/11/26).-Follow EBP while providing urinary catheter maintenance, contact with the catheter, tubing, and collection bag, and other high contact care activities. (Must wear gowns and gloves with urinary catheter, maintenance, contact with the catheter, tubing, collection bag, and other high contact care activities) (dated 6/12/26). During an observation and interview on 6/30/26 at 10:08 a.m., R13's room had a sign outside his room indicated he needed EBP for high contact care activities. Nursing assistants (NA)-G and NA-C entered R13's room and began attaching R13 to the full body mechanical lift. NA-G stated R13 had a wound and an indwelling urinary catheter. Neither NA-G nor NA-C had on a gown nor gloves. NA-G and NA-C then transferred R13 to bed and asked assistant director of nursing (ADON) to come into R13's room to perform wound care. ADON then entered R13's room with gown and gloves on and gave instructions to NA-G that she needed to have gown and gloves on during any high contact cares. NA-G then placed a gown and gloves on without performing hand hygiene. ADON removed R13's pad and NA-G cleansed stool from R13's bottom, NA-G then removed gloves and placed new gloves on without performing hand hygiene. NA-G then applied cream to R13's bottom and applied a new brief with the same gloved hands. NA-G stated for residents on EBP staff should be applying PPE prior to performing any high contact care activities, however, she did not apply the required PPE prior to assisting R13. ADON explained staff should absolutely be using EBP prior to doing high-contact care activities such as transfers, cares, and catheter care. During an interview on 6/30/26 at 10:44 a.m., director of nursing (DON) stated it was her expectation for staff to apply gown and gloves any time they performed high contact care activities and also perform hand hygiene at the appropriate times. Review of the facility's Enhanced Barrier Precautions Policy dated 11/25, identified it was the practice of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug resistant organisms (MDRO). Definition: Enhanced Barrier Precautions refers to the use of gown and gloves for use during high contact resident care activities for a resident known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition. (e.g., residents with wounds and indwelling medical devices). Implementation of EBP:-Make sure gowns and gloves are available.-Ensure access to alcohol-based hand rub in every resident room.-Position a trash can inside the resident room for discarding PPE.The infection preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. High-contact resident care activities include the following: Dressing; Bathing; Transferring; Providing hygiene; Changing linens/briefs or assisting with toileting; Device care or use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes); wound care.